DONNA BARTLETT, LCSW, LCAS, CMHT

New Patient Data and Insurance Form

DATE___________________

Client(s)Name ____________________________________ SSN _______________________________________
Address ____
City _______________________________________State ________________________ Zip ________________
Home Phone ________________ Work Phone _____________ Pager ____________ Cell Number _________
Date of Birth: _____/_____/_____ Gender: Male ___ Female ___

If Adult:
Name of Employer ____ Occupation __________________
Spouse/Partner's Name ____
In case of emergency notify ____
Name ____ Relationship _________________________________
Address _____________________________ City______________________ State/Zip __________________
Work Phone ____________________ Home Phone______________________ Cell Phone ________________

If Child/Student: Parent/Guardian's Name ____
Relationship to Child ___________________________ Best phone # to be reached at __________________
School Currently Attending/Grade/Year ____

Primary Care Physician ____
Address ____ City/State/Zip ________________________
Phone ____ Fax ______________________________________

Referral Source: How did you find out about my practice? Phone Book___ Radio Ads ___ Friend ___
HMO or Insurance Co. ___ EAP___ Employer___ Health Care Professional ___ Therapist ___ Attorney ___
Website ___ Brochure ___ Other ___ Information about person who made referral:
Name ____Phone ______________________________________
Address ___________________________City __________________State ______________ Zip ____________

INSURANCE INFORMATION

Bring your card with you to your first appointment

Guarantor Information (If other than self):
Name ____ Relationship _________________________
Address____________________________________ City ___________________ State__________ Zip________
Home Phone ____________________ Work Phone ___________________ Cell Phone __________________

Insurance Company __________________________________ Policyholder __________________________
Policyholder SSN ____ Date of Birth _____/_____/___
Employer_____________________________________ City ___________________ State/Zip______________

DEDUCTIBLE:____
NUMBER OF VISITS COVERED PER YEAR___________________________
NUMBER OF VISITS USED TO DATE_______________________________
COPAY____
BENEFIT YEAR START DATE_____________________________________